Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

PREMIUM DEDUCTION ELECTION

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name	
Department		**Department ID**	**Telephone**

REASON FOR ELECTION AGREEMENT

Date	Event	Date	Event
	☐ New Hire		☐ Moved in/out of the HMO area
	☐ Adoption/Guardianship*		☐ Needles Subsidy/Change in Subsidy Eligibility
	☐ Birth*		☐ Open Enrollment
	☐ Death*		☐ Reduction in Hours for Employee or Spouse/Domestic Partner*
	☐ Disabled Over-Age Dependent *(Please provide required Disabled Dependent Certification form)*		☐ Return from Unpaid Leave of Absence
	☐ Divorce/Dissolution of Domestic Partnership* *(Please provide required mailing address of ex-spouse/domestic partner)* Mailing Address: City, State, Zip:		☐ Unpaid Leave of Absence Taken by Employee or Spouse/Domestic Partner*
	☐ Gain/Loss Spouse's/Domestic Partner's Employment or Other Group Coverage*		☐ Other:
	☐ Marriage/Domestic Partnership*		

***Documentation is required for evidence of qualifying event** (i.e.; Birth Certificate, Certificate of Marriage/Domestic Partnership, Court Orders, Final Divorce Decree, Benefit Confirmation Statement, COBRA Notice, Loss of Coverage Letter, and Termination Notice)

BENEFIT ELECTIONS

Check the appropriate tax elections and list all dependents you wish to enroll in benefits.

Plan	Before Tax	After Tax
Medical	☐	☐
Dental	☐	☐
Voluntary Life	☐	☐
AD&D	☐	☐
Vision*	☐	☐

*Tax election for vision coverage applies only to Firefighters, Nurses, Probation, Specialized Peace Officer, and Specialized Peace Officer - Supervisory units

Name of Dependent	Tax Dependent		Domestic Partner/ Domestic Partner's Child	
	Yes	No	Before Tax	After Tax
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

HR Use Only

Comments

Enroll: ☐ Vision ☐ Life

DISTRIBUTION: Original - EBSD-HR (0440)

Reviewed By (Employee ID)	Date	Keyed By (Employee ID)	Date

Authorization and Certification

Employee signature is required for all qualifying events

I understand my share of the plan coverage cost may be adjusted to reflect any rate change. I acknowledge that my election is irrevocable unless there is a qualifying event in my family status and that in the absence of a family status change, my next opportunity to change this election will be during Open Enrollment. If I do not complete and return a new election form during Open Enrollment, the elections specified on page one of this Premium Deduction Election form will be maintained for the new plan year.

I hereby authorize the County of San Bernardino to obtain eligibility dates of coverage from previous Medical Plans for the exclusive purpose of determining my eligibility for the County of San Bernardino's Premium Conversion Benefit Plan as required under Internal Revenue Code Section 125. I understand this authorization is only in effect for **60** days from the date of my signature.

Needles Subsidy Eligible Employees: I understand that my eligibility for the "Needles Subsidy" is entirely contingent upon being assigned to Needles, Trona, or Baker as my work location. I understand that it is my responsibility to notify the Employee Benefits and Services Division (EBSD) should my assigned work location change to an area other than Needles, Trona, or Baker. I further understand that should it be discovered that the Needles Subsidy has been paid to me in error, that the County will collect, through payroll deduction, any amount of subsidy for which I received and was not eligible.

_____	_____	_____
Signature of Employee	Print Employee Name	Date

I understand my options in the Benefit Plan. I understand the County will reduce my salary in the amount of the plan coverage cost on either a before tax or after tax basis.

I understand that if at any time my or my family's eligibility changes, I will notify EBSD or department payroll specialist within **60** days of the change in order to make the appropriate changes to my benefit deductions. **For example, if I get divorced I am required to remove my ex-spouse from County sponsored Benefit Plans.**

I understand that I will be taxed on the fair market value of any benefits for any individual who is not my Federal/State tax dependent.

Employee Signature	**Date**

Payroll Specialist (Print & Sign)	**Telephone**	**Date**

Office Use Only

	Authorized Representative Signature	**Date**
☐ Approved		
☐ Denied		